BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **BRIAN PETERS, M.D.** Holder of License No. 28026 For the Practice of Medicine In the State of Arizona.	Case No. MD-01-0819 **CONSENT AGREEMENT FOR PROBATION**

CONSENT AGREEMENT

By mutual agreement and understanding, between the Arizona Medical Board ("Board") and Brian Peters, M.D. ("Respondent"), the parties agreed to the following disposition of this matter.

1. Respondent acknowledges that he has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Consent Agreement"). Respondent acknowledges that he has the right to consult with legal counsel regarding this matter and has done so or chooses not to do so.

2. Respondent understands that by entering into this Consent Agreement, he voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Consent Agreement in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Agreement.

3. Respondent acknowledges and understands that this Consent Agreement is not effective until approved by the Board and signed by its Executive Director.

4. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government

regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

5. Respondent acknowledges and agrees upon signing this Consent Agreement, and returning it (or a copy thereof) to the Board's Executive Director, Respondent may not revoke his acceptance of the Consent Agreement. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

6. Respondent further understands that this Consent Agreement, once approved and signed, is a public record that may be publicly disseminated as a formal action of the Board and will be reported to the National Practitioner Data Bank and to the Arizona Medical Board's website.

7. If any part of the Consent Agreement is later declared void or otherwise unenforceable, the remainder of the Agreement in its entirety shall remain in force and effect.

Brian Peters, MD
Brian Peters, M.D.

DATED: 8/14/03

Timothy Kasparek
Timothy Kasparek, Esq.
Attorney for Respondent
Approved as to Form

DATED: 8/14/03

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 28026 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-01-0819 after the Board was notified by Payson Regional Medical Center ("Hospital") that it had summarily suspended Respondent's hospital privileges.

4. The Board was subsequently notified by the Hospital that Respondent's summary suspension was vacated and that Respondent's general surgery privileges were reinstated.

PATIENT S.C.G. (#08-82-51)

5. On August 28, 2001, a 60 year old male ("S.C.G.") was referred to Respondent for an evaluation of aortoiliac aneurysmal and symptomatic occlusive disease. S.C.G. complained of short distance claudication at a distance of approximately 50 feet, and subsequently developed right foot pain that occurred primarily at night.

6. Respondent ordered and reviewed S.C.G.'s prior testing results that showed no detectible blood flow in the right posterior tibial or dorsalis pedis arteries on the right and an abdominal aortic aneurysm and a right iliac artery aneurysm.

7. Respondent's physical examination of S.C.G. revealed occult blood in the stool. Respondent had S.C.G. undergo a colonoscopy to evaluate for the possibility of colonic neoplasm. The colonoscopy revealed multiple colonic polyps.

8. S.C.G. then underwent an aortogram that confirmed aneurysmal disease, a 60-70% right iliac artery stenosis, right superficial femoral artery occlusion, a right popliteal artery occlusion and a right anterior tibial arterial occlusion. On S.C.G.'s left side, the aortogram showed occlusions at the superficial femoral artery, popliteal artery, and tibial perineal trunk.

9. S.C.G. presented to Respondent again and described a progression of his symptoms that now to included clear rest pain. Respondent discussed potential operative interventions and the attendant risks with S.C.G. and his wife. Respondent opined that the best operative approach for S.C.G. was an aortobifemoral bypass.

10. On September 24, 2001, S.C.G. was admitted to the Hospital to undergo an aortobifemoral bypass procedure.

11. Respondent, with assistance from another general and vascular surgeon, performed the procedure and encountered an unsuspected severe right profunda-femoral stenosis that required a right profunda endarterectomy and patch angioplasty. The repair significantly extended the surgical time.

12. On morning of September 25, 2001, S.C.G. had no movement in his lower extremities below the knees and his urinalysis was highly positive for hemoglobinuria or myoglobinuria. The laboratory tests results were consistent with myoglobinuria resulting from rhabdomyolysis.

13. Respondent interpreted the combination of paralysis and evidence of rhabdomyolysis and myoglobinuria in the context of recent vascular surgery as consistent with compartment syndrome. S.C.G. was emergently taken into the operating room to undergo a bilateral four compartment fasciotomy. S.C.G.'s diminished motor function was noted by the nursing staff overnight, but not communicated to Respondent, who became first aware the following morning.

14. Following this operative procedure S.C.G. developed renal insufficiency and respiratory failure requiring ventilator support. Subsequently, S.C.G. was transferred to another facility for further treatment with palpable pulses at the femoral level bilaterally.

15. A Board Medical Consultant ("Medical Consultant") reviewed this case and opined that the standard of care required Respondent to evaluate paralysis of the lower extremities post-surgery by a neurological examination in order to differentiate between spinal cord injury and compartment syndrome. The Medical Consultant found that Respondent deviated from the standard of care because failed to do a reasonable basic neurological evaluation that would have led to the diagnosis of spinal cord injury and, therefore, would have ruled out the need for a four compartment fasciotomy.

16. Two medical consultants independent of the Board, a vascular surgeon and a general surgeon, found that Respondent's fasciotomy surgery upon S.C.G. was appropriate and within the standard of care.

17. S.C.G. was harmed because he underwent unnecessary compartment syndrome surgery.

PATIENT T.C. (#07-76-95)

18. In the late evening of July 17, 2000, a 41 year old female ("T.C.") presented to the Emergency Room of the Hospital with complaints of arm swelling, redness and pain that developed 24 hours after injection of methamphetamine into her left forearm. The injection site was in the antecubital area and T.C. was evaluated as having extensive cellulitis emanating in the antecubital fossa.

19. Respondent was called in for a surgical consultation. Respondent evaluated T.C. as having severe cellulitis with the potential for necrotizing fasciitis as a progression of the infection, compartment syndrome from the associated edema and swelling, and suppurative thrombophlebitis from the injection and infection.

20. Respondent recommended admission to the Intensive Care Unit for aggressive antibiotic therapy and observation. T.C. underwent therapy, but after 8 hours of observation her arm worsened with an increase of tenderness and swelling.

21. On July 18, 2000, T.C. was taken into the operating room where Respondent performed exploratory surgery of her left arm. During this procedure, Respondent found necrosis of the subcutaneous fat with limited necrosis of the underlying muscle consistent with early necrotizing fasciitis versus severe soft tissue infection and bulging muscle on fascial release. The tissue was débrided and cultures were sent for pathology.

22. On July 20, 2000, the infection was found to be progressing onto the chest wall and T.C. was transferred to Good Samaritan Medical Center in stable condition. The

infection continued to progress and T.C. subsequently died while she was at Good Samaritan Medical Center.

23. A Board Medical Consultant ("Medical Consultant") reviewed this case and opined that the standard of care required Respondent to perform a wide and extensive debridement for gas forming infections and to do serial evaluations of the extent of the infection at least every 24 hours until control of the infection was assured or to immediately transfer the patient to a care facility that had hyperbaric oxygen therapy available. The Medical Consultant stated that Respondent deviated from the standard of care because failed to perform a wide and extensive debridement and to do serial evaluations of the extent of the infection at least every 24 hours until control of the infection is assured and/or immediately transfer the patient to a care facility that had hyperbaric oxygen therapy available.

24. A medical consultant (general surgeon) independent of the Board found that Respondent's care of T.C. was appropriate and within the standard of care. A second medical consultant (internal medicine and critical care), who was T.C.'s attending physician at Good Samaritan Regional Medical Center after transfer, reported and opined that Respondent provided proper surgical management and adequate surgical debridement prior to transfer from Payson; no further surgery or debridement was deemed necessary or done during T.C.'s admission to Good Samaritan. T.C.'s attending physician at Good Samaritan also reported and opined that Respondent made a reasonable decision regarding the timing of transfer of the patient, who died because she had a disease (clostridial necrotizing fasciitis) with extremely high morbidity and mortality at any institution.

25. T.C. died as a result of the uncontrolled infection.

PATIENT S.A.S. (#08-12-67)

26. A 60 year old female patient ("S.A.S.") presented to Respondent with multiple episodes of epigastric pain and a family history of colon cancer. Based upon this information, Respondent scheduled S.A.S. for an outpatient upper and lower endoscopy for evaluation of peptic ulcer disease and/or colonic neoplasm. Respondent was to perform the procedure.

27. On October 3, 2001, Respondent began the procedure with the upper endoscopy. During the upper endoscopy, Respondent discovered that S.A.S. had two gastric ulcers on the greater curvature of her stomach and one in the fundus.

28. Respondent biopsied the gastric ulcer and some bleeding from the biopsy site ensued. To stop the bleeding, Respondent attempted to use an electronic cautery instrument ("electric cautery") to cauterize the bleed site. There were technical problems with the electric cautery and several maneuvers were made to correct the problem. First, Respondent requested that the current be increased but the problem was not solved. Then, the endoscopy technician checked the connections while Respondent looked at the ulcer in the fundus. The grounding pad of the electric cauter was changed and the endoscopy technician told Respondent to try the electronic cautery apparatus again.

29. Respondent tried to use the electronic cautery, but it failed to function properly and a spark or "pop" occurred which resulted in a perforation of S.A.S.'s stomach.

30. Respondent immediately took S.A.S. into an operating room where he performed a primary repair of her perforation laparoscopically through three small stab incisions.

31. On October 4, 2001, S.A.S. was discharged in good condition and Respondent has seen her as a follow-up patient with no further problems.

32. Respondent stated the complication that occurred during S.A.S.'s endoscopic procedure resulted from a combination of machine failure and human error.

Respondent admitted that he should have asked the endoscopy technician to turn down the current even though the machine is typically returned to normal settings when a component is changed.

33. A Board Medical Consultant ("Medical Consultant") reviewed this case and opined that Respondent deviated from the standard of care because when he should have carefully monitored the settings on the equipment to avoid inadvertent injury.

34. The standard of care required Respondent to carefully monitor the setting on equipment to avoid inadvertent injury.

35. Respondent failed to meet the accepted standard of care because he failed to carefully monitor settings on equipment to avoid inadvertent injury.

36. S.A.S. was harmed because there was perforation of the stomach secondary to an electrocautery burn requiring surgery.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(24)(q) - ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is placed on probation for one year with the following terms and conditions:

A. Continuing Medical Education ("CME")

Respondent shall, with one year of the effective date of this Order obtain 10 hours of Board Staff pre-approved Category I CME in microbiological wound infections, including anaerobic organisms, and 10 hours of Board Staff pre-approved Category I CME

in the evaluation of spinal cord injuries and provide Board Staff with satisfactory proof of attendance. The CME hours shall be in addition to the hours required for the biennial renewal of medical license.

2. This Order is the final disposition of case number MD-01-819.

DATED AND EFFECTIVE this 15th day of August, 2003.

ARIZONA MEDICAL BOARD

By _____
BARRY A. CASSIDY, PH.D., PA-C
Executive Director

ORIGINAL of the foregoing filed this 15th day of August, 2003 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

EXECUTED COPY of the foregoing mailed by Certified Mail this 15th day of August, 2003 to:

Brian Peters, M.D.
P.O. Box 557
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EXECUTED COPY of the foregoing mailed this 15th day of August, 2003.

Timothy Kasparek, Esq.
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EXECUTED COPY of the foregoing hand-delivered this 15TH day of August, 2003, to:

Christine Cassetta, Assistant Attorney General
Sandra Waitt, Management Analyst
D.K. Keenom, Division Chief, Enforcement
Arizona Medical Board
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Scottsdale, AZ 85258

Brenda Aplin
Board Operations